**Definition**
Erectile dysfunction is the inability to attain and maintain an erection sufficient for satisfactory sexual performance.

**History:**
- Sexual history is essential to differentiate psychological from physical causes or mixed picture
  - e.g. presence of early morning erections/able to masturbate?
  - Enquire about lifestyle
  - Consider the following pathophysiology in history
    - Vasculogenic: e.g. CVD, hypertension, diabetes mellitus, hyperlipidaemia, smoking, major surgery or radiotherapy
    - Neurogenic: e.g. MS, Parkinson's Disease, CVA, alcoholism, diabetes, tumours
    - Hormonal: e.g. hypogonadism, thyroid, hyperprolactinaemia
    - Anatomical: e.g. Peyronie's Disease, congenital
    - Drug induced: (see notes)
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  - Drug induced: (see notes)

**Examination:**
- Cardiovascular, neurological and endocrine
- Genitourinary
- Digital Rectal Examination (if appropriate) to eliminate Ca Prostate

**Investigations:**
- FBC, U&Es, LFTs, fasting glucose & lipids
  - Total Testosterone (measure in the morning between 8-11am)
    - If testosterone result low, confirm with second sample and also check SHBG, LH, FSH & Prolactin
  - PSA (if appropriate and only after appropriate counselling)

- Give lifestyle advice as appropriate
- Assess patient's needs and expectations

**Treat reversible causes & reassess**

**No better**

**No reversible causes**

**Unsuitable/unable to take PDE-5 inhibitor**

**Trial of PDE-5 inhibitor**
In accordance with CWS Medicines Management formulary

**No response**

**Refer Patient to Specialist Service**

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Adapted from NHS Camden Clinical ED Pathway

Coastal West Sussex
Clinical Commissioning Group

Western Sussex
Hospitals
NHS
Erectile Dysfunction Notes

1). Examples of drugs causing ED:
- Antihypertensives:
- Psychotropic drugs: phenothiazines, tricyclics, MAOIs, SSRIs, lithium
- Hormone modifying drugs: cyproterone acetate, oestrogen, 5-alpha reductase inhibitors, corticoseroids, progesterone
- Cytotoxics: cyclophosphamide, methotrexate
- Recreational drugs: alcohol, tobacco, cannabis
- Other: digoxin, ranitidine, carbamazepine, spironolactone, digoxin

2). Lifestyle advice/interventions:
- Increase exercise
- Reduce BMI
- Smoking cessation
- Reduce alcohol intake

3). Treatment of reversible causes:
- Treat any obvious underlying cause if possible in primary care (hypothyroidism, DM etc)
- If significant endocrine abnormality is discovered, refer to endocrinologist

Diagnosis of low testosterone and testosterone replacement:
If a GP feels confident to manage testosterone replacement in primary care this may be undertaken but attention must be paid to the WSHT Male Hypogonadism guidelines.

4). Unsuitability for treatment with PDE-5 inhibitor:
- PDE-5 inhibitors must not be prescribed in conjunction with nitrates or Nicorandil
- Men with intermediate or high cardiovascular disease - see (BSSM) guidance on ED

British Society of Sexual Medicine

5). Treatment with PDE-5 inhibitors:
- Check suitability for prescribing under NHS Schedule 11
- Refer to BNF for notes on how to take PDE-5 inhibitors – essential to explain details to patient as failure of treatment often results from taking incorrectly
- Important to explain side effects and risk of priapism
- Trial of at least 2 PDE-5 inhibitors over 8 occasions at maximum dose before referral
- Sexual stimulation must occur for any PDE-5 inhibitor to work

6). PDE-5 inhibitors in psychogenic ED:
It is reasonable to give a trial of PDE-5 inhibitors to suitable men with psychogenic ED in conjunction with psycho-sexual support in a move to boost confidence.

Useful patient resources:
http://www.nhs.uk/Conditions/Erectile-dysfunction/Pages/Treatment.aspx
http://www.patient.co.uk/health/Erectile-Dysfunction-%28Impotence%29.htm